



September 28, 2001

Common Identification Number A-06-01-00027

Mr. Bruce Hughes  
Executive Vice-President and Chief Operating Officer  
Palmetto Government Benefit Administrators, LLC  
P.O. Box 100134  
Columbia, SC 29202-3134

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report titled "Review of Requests for Anticipated Payment under the Medicare Home Health Prospective Payment System at Palmetto Government Benefit Administrators, LLC between October 1, 2000 and April 26, 2001." A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-06-01-00027 in all correspondence relating to this report.

Sincerely,

A handwritten signature in black ink that reads "Gordon L. Sato".

GORDON L. SATO  
Regional Inspector General  
for Audit Services

Enclosure- as stated

Direct Reply to HHS Action Official:

John Delaney  
Southern Consortium Contractor Management Officer  
Centers for Medicare and Medicaid Services  
1301 Young Street, Room 714  
Dallas, TX 75202

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF REQUESTS FOR  
ANTICIPATED PAYMENT UNDER  
THE MEDICARE HOME HEALTH  
PROSPECTIVE PAYMENT SYSTEM  
AT PALMETTO GOVERNMENT  
BENEFIT ADMINISTRATORS, LLC  
BETWEEN OCTOBER 1, 2000  
AND APRIL 26, 2001**



**SEPTEMBER  
2001**

# *Office of Inspector General*

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The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## *Office of Audit Services*

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

## *Office of Evaluation and Inspections*

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

## *Office of Investigations*

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

## *Office of Counsel to the Inspector General*

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF REQUESTS FOR  
ANTICIPATED PAYMENT UNDER  
THE MEDICARE HOME HEALTH  
PROSPECTIVE PAYMENT SYSTEM  
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# *Notices*

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**THIS REPORT IS AVAILABLE TO THE PUBLIC  
at <http://www.hhs.gov/oig>**

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Audit Services' (OAS) reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5)

## **OAS FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.



September 28, 2001

Our Reference: Common Identification Number: A-06-01-00027

Mr. Bruce Hughes  
Executive Vice-President and Chief Operating Officer  
Palmetto Government Benefits Administrators, LLC  
P.O. Box 100134  
Columbia, SC 29202-3134

Dear Mr. Hughes:

The purpose of this report is to inform you of the results of our review of requests for anticipated payments (RAPs) under the Medicare home health (HH) prospective payment system (PPS) at Palmetto Government Benefits Administrators, LLC (Palmetto). The objective of our review was to determine if Palmetto, a regional home health intermediary (RHHI), was paying RAPs only for services that are covered under the Medicare HH PPS. Due to system problems with the Fiscal Intermediary Standard System (FISS), Palmetto improperly paid about \$15 million to home health agencies (HHAs) for non-covered and denied charges. As of April 26, 2001, our last day of fieldwork, Palmetto had not recovered these overpayments.

Under the HH PPS, HHAs are paid based on a 60-day episode. Each episode is paid in two payments: one as a RAP at the beginning of the episode and one as a claim at the end of the episode. For initial episodes, HHAs receive 60 percent of the payment amount as a RAP and 40 percent as a final claim at the end of the episode. For subsequent episodes, HHAs receive 50 percent as a RAP and 50 percent as a final claim.

As a result of the system problems, Palmetto overpaid 1,820 HHAs approximately \$15 million for non-covered and denied charges on 9,707 RAPs processed through the electronic HH PPS between November 2, 2000 and the first week in December 2000. The overpayments resulted from a programming error with the FISS software. The FISS software ignored the Medicare non-covered and denied charge information and improperly paid RAPs for such charges. The problem affected rejected RAPs containing no Medicare covered charges. The FISS staff sent a software fix to the RHHIs to correct this problem on December 1, 2000 and Palmetto installed it on December 7, 2000. We did not perform any tests to verify that this problem was corrected by the software fix during our review.

The RHHIs are required to make timely and aggressive efforts to recover overpayments according to the Medicare Intermediary Manual (MIM) 13-2 Section 2220. During our March 26, 2001 entrance conference, we asked about HH PPS problems and Palmetto stated that it would provide a list of problems to us. Palmetto gave us a copy of its January 15, 2001 memorandum to the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration, describing this HH PPS processing problem. In this memorandum, Palmetto estimated that in excess of \$17 million was paid incorrectly and stated

that it would have to recoup these overpayments. Two days after the entrance conference, March 28, 2001, Palmetto requested its information systems staff run a computer program to identify these overpayments. On April 5, 2001, we requested the data identifying the overpayments. Palmetto stated that it had not identified the actual amount of this overpayment and the \$17 million amount was just an estimate. On the same date, Palmetto requested that its information systems staff rerun the computer program in a different format. On April 25, 2001, Palmetto stated that they had just identified that approximately \$15 million was paid incorrectly and provided us with summary information to support this amount. As of April 26, 2001, Palmetto had not recovered these overpayments. Palmetto officials indicated that the overpayments had not been recovered because it would require a significant effort to make the necessary adjustments.

We recognize that Palmetto installed the necessary software fix. However, we are concerned about Palmetto's ability to recover the RAP amounts that some HHAs improperly received about 6 months ago. As a result of the system problems, Palmetto improperly paid approximately \$15 million for RAPs to HHAs for services that were not covered by the Medicare program. These RAPs were intended to provide an adequate cash flow to HHAs to maintain quality Medicare covered services to beneficiaries. Under HH PPS, HHAs receive a significant amount of money by submitting RAPs before most HH services are provided for a 60-day episode. These HHAs have received more money than they were entitled to and have not been required to promptly return such funds. A RHHI's ability to collect Medicare overpayments is affected by a number of different factors, including the promptness with which overpayments are identified.

We are recommending that Palmetto (i) take action to recover improperly paid RAPs and (ii) implement procedures to ensure that future overpayments are identified and recovered timely.

At the June 27, 2001 exit conference, Palmetto stated that it manually cancelled the improperly paid RAPs between May 10 and May 24, 2001. In its July 13, 2001 response to our draft report, Palmetto stated that it had systematically recouped 95 percent of the amount due. Palmetto believes that it acted timely in identifying and recovering the improperly paid RAPs. Palmetto stated that it and staff from CMS and other RHHIs worked to identify all issues related to the new HH PPS. In effect, Palmetto has partially implemented the recommendation contained in our draft report pertaining to the recovery of overpayments resulting from the system problems. We did not perform any tests to verify that Palmetto (1) cancelled these improperly paid RAPs and (2) correctly calculated the amount systematically recouped. We plan to follow-up on Palmetto's recovery actions in the future.

## **BACKGROUND**

The Balanced Budget Act of 1997, amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999 and the Balanced Budget Refinement Act of 1999, created a PPS for HHAs. The HH PPS was implemented on October 1, 2000. The unit of payment in the HH PPS is based on a 60-day episode. Each episode is paid in two payments: one as a RAP at the beginning of the episode and one as a claim at the end of the episode. For the initial episodes, HHAs receive 60 percent of the payment amount as a RAP, and the

remaining 40 percent at the end of the episode when the claim is submitted. For subsequent episodes, HHAs are paid 50 percent as a RAP and 50 percent as a final claim. Detailed tracking and accounting systems are required at the RHHIs to process RAPs. Palmetto used the FISS software to process RAPs and final claims for HHAs located in 16 states. These tracking and accounting systems began electronically processing RAPs on November 2, 2000.

Medicare contractors, called RHHIs, process bills and make payments to the HHAs. Each RHHI must administer the Medicare program efficiently and economically. The basic principles of the Medicare program are to pay claims promptly and accurately. The 42 CFR Section 421.100(a)(ii) requires RHHIs to ensure that they make payments only for services that are covered under Medicare.

On July 24, 2000, the CMS issued a Contractor Performance Evaluation report to Palmetto summarizing its findings of the review of Overpayment, Payment Safeguards Criterion Section 2901.3 for the period from October 1, 1999 through May 31, 2000. One of the program vulnerabilities cited in this report was that Palmetto did not perform aggressive recovery action of overpayments. Palmetto concurred with this finding and stated that it was committed to identifying ways to ensure that overpayments are liquidated as quickly as possible.

## **SCOPE**

The objective of our review was to determine whether Palmetto was paying RAPs only for services that are covered under the Medicare HH PPS. We performed a limited scope review at Palmetto's office in Columbia, South Carolina from March 26, 2001 through April 26, 2001.

We interviewed Palmetto staff to obtain a general understanding of the HH PPS and how it was operating. Palmetto provided us with a listing of HH PPS processing problems since the implementation of HH PPS. We also obtained a copy of the documentation concerning actions of the FISS staff to correct its software error of paying for non-covered and denied charges. We talked to CMS Central Office personnel about this software problem. We also received documentation from Palmetto identifying the number and amount of RAPs that were improperly paid and not recovered from various HHAs. We did not contact the affected HHAs to verify the amounts of the overpayments.

## **FINDINGS AND RECOMMENDATION**

Due to system problems with FISS, about \$15 million was improperly paid to home health agencies for non-covered and denied charges. At the time of our fieldwork, Palmetto had not taken action to identify and recover these overpayments from 1,820 HHAs resulting from 9,707 RAPs processed through the electronic HH PPS between November 2, 2000 and the first week in December 2000. The overpayments resulted from a programming error with the FISS software used to process payments for HHAs at Palmetto. Palmetto installed the necessary software fix on December 7, 2000. It identified the improperly paid RAPs during April 2001. As of April 26, 2001, about 6 months since these overpayments began, Palmetto had identified the rejected RAPs with non-covered and denied charges but it had not recovered them.

**Uncollected Non-covered and Denied Charge Payments**

A programming error with the FISS software caused overpayments for non-covered and denied charges to be made to HHAs. The FISS staff received information about this error on November 15, 2000 and began its research. The FISS software ignored the Medicare non-covered and denied charge information and improperly paid RAPs for such charges. The problem affected rejected RAPs containing no Medicare covered charges. If a RAP paid for Medicare covered charges along with non-covered and denied charges, the HH PPS automatically recouped these improperly paid funds. The FISS staff sent a software fix to the RHHIs to correct this problem on December 1, 2000. Palmetto installed this fix on December 7, 2000. We did not perform any tests to verify that this problem was corrected during our review.

During our March 26, 2001 entrance conference, we asked about HH PPS problems and Palmetto stated that it would provide a list of problems to us. Palmetto gave us a copy of its January 15, 2001 memorandum to CMS Central Office staff describing this HH PPS processing problem along with an example. In this memorandum, Palmetto estimated that in excess of \$17 million was paid incorrectly and stated that it would have to recoup these overpayments. On March 28, 2001, 2 days after we started our fieldwork, Palmetto requested its information systems staff run a computer program to identify these overpayments. On April 5, 2001, we requested support for recovery of the overpayments. Palmetto stated that they had not identified the actual amount of this overpayment. On the same date, Palmetto requested that its information systems staff rerun the computer program in a different format. On April 25, 2001, Palmetto stated they had just identified that approximately \$15 million was paid incorrectly and provided us with support for this amount. As of April 26, 2001, our last day of fieldwork, Palmetto had not recovered these overpayments.

We recognize that Palmetto installed the necessary software fix. However, we are concerned about Palmetto’s ability to recover these RAP amounts that some HHAs improperly received about 6 months ago. As a result of system problems, Palmetto improperly paid approximately \$15 million for RAPs to HHAs for services that were not covered by the Medicare program. The chart below shows the range of inappropriate RAP amounts that these HHAs received.

<b>Range of RAP Amounts Improperly Paid</b>		<b>Number of HHAs</b>
<i>From</i>	<i>To</i>	
\$1	\$5,000	990
\$5,001	\$10,000	434
\$10,001	\$20,000	246
\$20,001	\$30,000	74
\$30,001	\$40,000	32
\$40,001	\$50,000	17
\$50,001	\$301,330	27
<b>Total</b>		<b>1,820</b>

Of the 1,820 HHAs, 27 inappropriately received between \$50,001 and \$301,330. Palmetto inappropriately paid \$301,330 to 1 HHA.

These RAPs were intended to provide an adequate cash flow to HHAs to maintain quality Medicare covered services to beneficiaries. Under HH PPS, HHAs receive a significant amount of money by submitting RAPs before most HH services are provided for a 60-day episode. These HHAs have received more money than they were entitled to and have not been required to promptly return such funds. A RHHI's ability to collect Medicare overpayments is affected by a number of different factors, including the promptness with which the overpayments are identified. The RHHIs are required to make timely and aggressive efforts to recover overpayments according to the Medicare Intermediary Manual (MIM) 13-2 Section 2220.

### **Recommendations**

We recommend that Palmetto (i) take action to recover improperly paid RAPs and (ii) implement procedures to ensure that future overpayments are identified and recovered timely.

### **AUDITEE COMMENTS AND OIG RESPONSE**

In its response to our draft report, Palmetto indicated that it identified the improperly paid RAPs during April 2001 and cancelled the erroneously paid RAPs between May 10 and May 24, 2001. Palmetto stated it recouped 95 percent of the amount due as of July 13, 2001. Palmetto also stated that it had not recovered \$743,917 of improperly paid Medicare funds to 23 providers.

Palmetto believes that it acted timely in identifying and recovering the improperly paid RAPs. Palmetto stated that it and staff from CMS and other RHHIs worked to identify all issues related to the new HH PPS. At a February 2001 meeting, Palmetto indicated that it was decided that this problem warranted a standard FISS system correction to identify and recoup the improperly paid amounts. To avoid double recoupment, Palmetto also had to wait 120 days from the *coverage from date* of the improperly paid RAPs to determine if the FISS system would automatically cancel such RAPs. In mid-March, Palmetto verified that the improperly paid RAPs did not automatically cancel through FISS. Palmetto decided, with CMS' concurrence, to manually cancel the RAPs rather than wait on a standard FISS system correction. During April 2001, it identified the improperly paid RAPs. Between May 10 and May 24, 2001, Palmetto stated it cancelled the improperly paid RAPs and the systematic collection of these amounts began. As of July 13, 2001, Palmetto stated that it had systematically recouped 95 percent of the amount due to the Medicare program.

Palmetto also indicated that it is continuing its quality assurance review of their cancellation process and will monitor the outstanding balances for the remaining 23 providers to ensure full collection of amounts paid in error.

Page 6 – Mr. Bruce Hughes

In effect, Palmetto has indicated that it partially implemented the recommendation contained in our draft report to recover the improperly paid RAPs. We plan to follow up on Palmetto's recovery actions in the future. We continue to believe that Palmetto should implement procedures to ensure that future overpayments are identified and promptly recovered.

A copy of Palmetto's response is included as Appendix A.

Sincerely,

A handwritten signature in black ink that reads "Gordon L. Sato". The signature is written in a cursive style with a large initial "G".

GORDON L. SATO  
Regional Inspector General  
for Audit Services

Enclosure



**Medicare  
Palmetto GBA**

Post Office Box 100134  
Columbia, South Carolina 29202-3134

*Bruce W. Hughes  
Executive Vice President and Chief Operating Officer*

July 13, 2001

Mr. Gordon L. Sato  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of Inspector General  
Office of Audit Services  
1100 Commerce, Room 6B6  
Dallas, Texas 75242

**RE: Review of Requests for Anticipated Payments Under the Medicare Home Health Prospective Payment System.**

Dear Mr. Sato,

We received the draft report on the results of the Office of Inspector General's (OIG's) review of requests for anticipated payments (RAPs) under the Medicare home health prospective payment system (HH PPS). As requested, we reviewed the reports and are providing (1) written comments as to the completeness and accuracy of the information presented, and (2) additional information we believe is pertinent to the draft report.

According to the draft report the objective of your review was to determine if Palmetto GBA, LLC (Palmetto), a regional home health intermediary (RHHI), was paying RAPs only for services that are covered under the Medicare HH PPS. This is not the objective communicated to Palmetto by the auditors during their three-week on-site visit at Palmetto. The OIG's stated objective was to review the Centers for Medicare and Medicaid Services' (CMS's) implementation of the HH PPS. As we understood, both from your office and CMS, the official entrance conference for this audit took place via teleconference with CMS central office staff in Baltimore. No one from Palmetto participated in the official entrance conference held via teleconference.

Upon arrival at Palmetto, the OIG auditors said that in order to review the implementation of the HH PPS, they had to come on-site to an RHHI to see how the claims flowed through the Fiscal Intermediary Shared System (FISS). Palmetto was selected over the other two RHHIs that use the FISS due to the large volume of claims we process. Again, presumably because Palmetto was initially not the focus of the audit, there was no exit conference when the OIG auditors concluded their visit at Palmetto. It was not until after the draft report had been written that the OIG contacted Palmetto by telephone to let us know that the objective of the audit had changed. From the report you provided, it is unclear as to the reason the objective of the OIG's review changed so significantly.

However, it appears the focus of the review was narrowed to determining if Palmetto, as an RHHI, had paid RAPs inappropriately rather than reviewing the overall implementation of HH PPS by CMS and its contractors.

Mr. Gordon L. Sato  
July 13, 2001  
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As the draft report states, during the initial implementation of the HH PPS, there was a software programming error in the FISS that caused payment to be issued on RAPs that should have been rejected to the provider. This problem occurred for claims submitted in November and December 2000. On January 3, 2001, the FISS staff sent a software fix to the three RHHIs to correct this problem for future claims submissions. After testing the fix, Palmetto installed it on January 8, 2001.

Palmetto notified CMS of the impact of this as well as other software issues in an email memorandum sent January 15, 2001. Palmetto told the OIG auditors of this FISS issue as well as the other known FISS issues, two of which caused home health providers to be underpaid for covered Medicare services during this same time period. **The FISS issues that resulted in underpayments to the providers were not included in the draft report.**

From the inception of the Medicare program, home health agencies were paid on a reimbursable cost basis for the money they spent providing care to beneficiaries. Implementing a system to make home health payments for Medicare services on a prospective basis was a major CMS priority. CMS devoted significant resources to ensure a smooth claims system conversion for home health agencies that converted to prospective payment for service periods beginning October 1, 2000. As with the implementation of any new payment system of this magnitude, some programming problems do occur. The CMS and Palmetto were very committed to ensuring uninterrupted cash flow to providers during the major transition of billing and claims processing systems, as the overall political climate was to first and foremost ensure providers were being paid under the HH PPS system. This was further demonstrated by the Congress's decision to issue extra PIP payments in February 2001 to providers formerly paid via periodic interim payments.

Together, CMS and its contractors worked to identify all issues related to the new claims processing system and prioritized them based on impact to the home health industry and risk to the Medicare program. Palmetto was very proactive in the efforts to identify and address these issues. CMS held a meeting in Baltimore on February 1 and 2, 2001 for RHHIs to discuss all known claims processing issues related to HH PPS.

At the February 2001 meeting in Baltimore, it was decided that the scope of the processing problem that caused home health providers to be erroneously paid for rejected RAPS would warrant a standard system solution to identify and recoup the amounts paid in error. However, before doing this one of the factors to consider was whether or not the system would automatically handle the RAPs paid in error. For regular RAPs that process through the system, if a final claim is not submitted 120 days after the *coverage from date* of the RAP, the system automatically cancels the RAP payment made to the provider. An unknown factor was whether or not this auto-cancel process would occur for the rejected RAPs that paid in error. To effectively make this determination, it was necessary to wait 120 days or more from the *coverage from date* of the erroneously paid claims to see if they automatically cancelled through FISS. Without waiting there was a potential to double recoup the amounts paid in error to the providers. This would have caused an adverse impact to the home health industry, in what they would view as a relatively short time period after implementation of a new payment system.

In mid-March it was verified that the erroneously paid RAPs did not auto-cancel through FISS. Because of FISS immediate priorities to work on claims issues having a negative impact on providers, it was decided by Palmetto, with CMS concurrence, to manually cancel the claims rather than wait on a standard FISS system correction. The design specifications for the reports needed to cancel the erroneously paid RAPs were developed and given to our programmers who created the test run of the report the end of March 2001. The reports were tested and revisions were suggested to the

Mr. Gordon L. Sato  
July 13, 2001  
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programmers who recreated the reports in April 2001. Proper design specifications and report testing were critical to ensure proper identification of all erroneously paid RAPs.

The reports identifying the erroneously paid RAPs were generated a third time with provider page breaks. Each affected provider received their provider-specific report along with a letter explaining the problem, how it was being corrected, and how to identify it on their remittances. Because of the way the erroneously paid claims flowed to the remittance advice, it was difficult for some providers to realize they had been overpaid. As a customer service effort to our providers, in addition to the letters and report copies, we also contacted each State Association for the 16 states we service and posted information about the problem on our website.

Palmetto manually cancelled the erroneously paid claims May 10 through May 24. The cancellation process creates a claims accounts receivable due the Medicare program. These claims accounts receivables are collected from the next available claims payment due to the impacted providers. Systematic collections are the quickest and most effective way to recoup the monies due Medicare while providing a good paper trail of the amounts taken back. It appears only 23 of the 1820 providers have balances due the Medicare program as a result of this system's error. The amount still to be collected is \$743,916.97, which represents less than 5% of the total paid in error. Additionally, we are currently performing a detailed quality assurance review of our actions related to the recovery of these overpayments.

While it is true that 1820 providers were temporarily overpaid nearly \$15 million dollars, the following statistics provide perspective on the relative extent of the problem.

- Palmetto processed 1,037,531 claims in November and December 2000. **Less than one percent of the claims processed were affected by this issue.**
- Palmetto paid \$782 million in Medicare benefits in November and December 2000. **Less than two percent of the total payments are affected by this issue.**
- **On average the issue resulted in 4.7 erroneously paid claims per provider with an average overpayment of \$7,010.**
- **54% of the affected providers were overpaid less than \$5,000.**
- **78% of the affected providers were overpaid less than \$10,000.**
- **92% of the affected providers were overpaid less than \$20,000.**

It is our opinion that Palmetto acted appropriately in recovering the amounts paid in error. As explained above many factors had to be collectively taken into consideration when making the decision of timing for collection of this overpayment. The implementation of the HH PPS was politically sensitive with CMS being very concerned about any negative or adverse impacts to the cash flow of home health agencies. CMS's first priority was to get HH PPS implemented. We believe, as does CMS, that Palmetto acted timely in identifying and recovering RAP overpayments resulting from this isolated systems problem.

Mr. Gordon L. Sato  
July 13, 2001  
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The draft report also references a July 24, 2000 CMS issued Contractor Performance Evaluation report issued to Palmetto. This report summarized CMS findings from their on-site review at Palmetto of the Overpayment, Payment Safeguards Criterion for the period from October 1, 1999 through May 31, 2000. One of the program vulnerabilities cited in this report was that Palmetto did not perform aggressive recovery action of overpayments. This finding was specific to lack of follow-up on cost report and interim rate overpayments caused by the interim payment system (IPS), not claims system overpayments. In May 2001, CMS was again on-site for the same review for the period from October 1, 2000 through April 2001. Although the formal report has not been issued, CMS stated during the formal exit conference that this vulnerability no longer existed and that Palmetto has shown significant improvement in the area of aggressively collecting aggregate overpayments.

One of the positive findings from the most recent overpayment CPE review were Palmetto's efforts to ensure phase-in RAP payments and contingency payments were not issued to high risk providers. Phase-in payments were issued to providers during October 2000 until the FISS system became operational November 2, 2000. Contingency payments were issued to providers who were unable to submit HH PPS claims in October and November 2000. The CMS commended Palmetto for the efforts it took to ensure both phase-in and contingency RAP payments were issued only to eligible providers. Palmetto issued \$206.8 million in phase-in and contingency payments and was also able to recoup 98% of the amounts issued within 90 days.

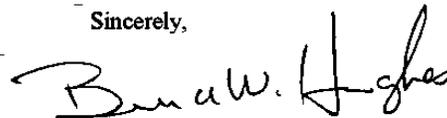
The draft report recommends that Palmetto **See Auditor's Note Below.**

implement  
procedures to ensure that future overpayments are identified and recovered timely.

As outlined above, Palmetto has already cancelled the claims paid in error and has systematically recouped 95% of the amounts due the Medicare program. We will continue our quality assurance review of our cancellation process and we will also monitor the outstanding balance due from the remaining 23 providers to ensure full collection of amounts paid in error. Palmetto has procedures in place to identify both aggregate and claims related overpayments and to ensure timely and appropriate collection. When claims are paid erroneously through the FISS, there is a process in place to notify FISS. A workgroup consisting of FISS, contractor, and CMS staff members prioritize outstanding claims system issues.

Thank you for responding to our request of June 5, 2001 to have an exit conference on this matter. We trust that as a result of discussions at the June 27, 2001 exit conference and our response to the draft report that the OIG will concur Palmetto acted both timely and responsibly in collecting the amounts paid in error due to the FISS programming problem. If you have any questions concerning Palmetto's response to this draft report, please contact Lisa Hutchinson, Reimbursement Manager, at (803) 735-1034, extension 26213, or me at (803) 763-7130.

Sincerely,



cc: Mr. John Delaney, CMS – Dallas  
Ms. Dale Ivey, CMS – Atlanta  
Mr. Ron Smith, CMS – Atlanta  
Ms. Elizabeth Carmody, CMS – Baltimore  
Mr. Wil Gehne, CMS – Baltimore

Auditor's Note: This pertains to an issue which is not in the final report.